

## Log For All Facility Incidents

**Facility Name:**

**State ID Number:**

**Provider ID Number: 23-**

**Reporting Period** \_\_\_\_\_ **Year**

10/1 thru 12/31 [ ]      1/1 thru 3/31 [ ]

4/1 thru 6/30 [ ]      7/1 thru 9/30 [ ]

Resident Name and Code*	Room #	Diagnosis	Date of Event	Describe Event/Incident and Outcome	Injury Y or N Describe injury	Date Facility Investigation Complete	Describe Intervention Implemented	Reported to State Y – N Date

**Person responsible for this report**

**Title**

- Please note that this form must be filed with your Licensing Officer quarterly (forwarded by 15<sup>th</sup> of the month following the end of the quarter) or more frequently as directed. If there are no events to report on this log, write “NONE” and submit as required.

**Gaylord Fax Number: (989)732-8958**

**Detroit Fax Number: (313)456-0348**

**Lansing Fax Number: (517)334-8473**

For incidents that occur on or after December 1, 2006.

- \*CODE:** A = Resident directly involved in accident or incident who may have suffered injury.  
B = Resident, staff person or other individual who may have been involved in accident or injury.